

CROSS TRAILS MEDICAL CENTER

Patient Registration Form

Revised 4/13/2016

Patient Information			
Last Name	First Name	MI	Social Security Number
/ /	M / F	Single / Married / Widowed / Divorced	
Birthdate	Sex	Marital Status	
Address			
City		State	Zip Code
Home Phone		Cell Phone	Work Phone
Ok to leave message? Yes / No			
Email Address: _____			
Emergency Contact	Relationship to Patient	Home Phone	Work Phone
Responsible Party Information (if other than the patient)			
Last Name	First Name	MI	Social Security Number
/ /	M / F	Single / Married / Widowed / Divorced	
Birthdate	Sex	Marital Status	
Address			
City		State	Zip Code
Home Phone		Cell Phone	Work Phone
Do you have a preferred pharmacy? Yes / No			
Pharmacy: _____		Phone Number: _____	
Address: _____			

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FOR PRIVATE INSURANCE PATIENTS -

Cross Trails Medical Center utilizes our in-house laboratory to process any labwork you may need. If your insurance company requires your lab work to be sent to a specific lab please indicate below.

Cross Trails	Southeast Hospital Lab
LabCorp	St. Francis Lab
Quest	Other (please specify) _____

DUE TO GOVERNMENT REGULATIONS WE ARE REQUIRED TO ASK THE FOLLOWING INFORMATION:

What is your race?

Asian	Black/African American	Pacific Islander	More than one race
White	Native Hawaiian	American Indian/Alaska Native	Refused to Report

What is your ethnic background?

Hispanic/Latino	Non-Hispanic/Latino	Refused to Report
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What language other than English would best serve you? _____

What is your Gender Identity?

Male	Transgender Male/Female to Male	Gender Queer	Choose not to disclose
Female	Transgender Female/Male-to-Female	Other	

What is your sexual orientation?

Straight or heterosexual	Bisexual	Don't Know
Lesbian, gay or homosexual	Something Else	Choose not to disclose

Are you a U.S. Veteran?

Yes No

What is your education level? _____

What is your occupation? _____

What is your yearly household income? _____

Refused

How many persons are in your household? _____

Authorization : I hereby authorize the physician above to furnish information to insurance carriers concerning myself and my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance.

Authorization : I hereby authorize payment of medical benefits to Cross Trails Medical Center.

Authorization : I hereby give permission for laboratory treatments and procedures, health history and physical assessment, mental health evaluation and treatment to be performed.

Authorization : I hereby request that my medical records, laboratory results, x-ray results and all pertinent information to be released to Cross Trails Medical Center.

Date

Signature of patient, parent or guardian